# DBP Clinical Conference: Case Presentation

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# Case Presentation

- CW is a 7.5 year old boy
- Parental Concerns: quiet, anxious around new people, and want him to have more friends,
- HPI: CW speaks English and Mandarin with his brother, mother, and father.
  - He will speak in full sentences with them (new development in last 1.5 yrs from 1-2 words).
  - He does not talk to friends at school, or read out loud to the teacher. Clark has never fully developed these skills.
  - Always feels uncomfortable in social situations when having to interact with peers or other adults. He is afraid to make new friends
  - He does not go out by himself, does not enjoy exploring by himself, but he is not afraid of being in crowds.

- He is friendly with his brother, they play together frequently. Parents brought in videos of Clark interacting normally with his brother.
- He has had speech therapist sessions once a week during lunchtime at school since May.
- The teacher assessment shows concerns for reading, writing and math.

- PMH: None

- Family History:
  - Dad describes himself as being shy and did not start talking until sixth grade.  He was slow to learn and started college at age 20. (but not as anxious)
  - Dad has skeletal disease growing up, where he had multiple surgeries to remove bone growth at the end of his long bones, multiple exostosis congenita
- Social History: mother, father, and 6 yo brother
- Developmental Hx: Able to run and play with peers. Plays piano with both hands. Walked at 18 months. Said first word at 12 months.

- ROS: Concern for absence seizures
- PE:
  - 3rd % for height and weight.
  - Quiet, sits in chair next to father. Answers no questions verbally but does shake his head. When crying, needs to hide behind dad or lay in moms lap
  - Does not say one work to examiner, whispers in Mandarin to mom
  - Otherwise normal
- Wechsler Nonverbal Scale of Ability : FSIQ was 93, 32nd %. No significant delay in CW's nonverbal cognitive abilities, but concerns for writing.
- VMI: Score of 89, low-average, 23rd%. Difficulty with spacing and pencil control.

# Differential?

# Differential diagnosis

- Selective Mutism
- Social/Situational:
  - Children who moved/immigrated recently: may refuse to speak with strangers (if last longer consider diagnosis)
  - Shy child- may be shy for hours, but eventually warms up and functions
- Oppositional defiant disorder- refusing to speak to manipulate surroundings
- Communication disorders (Language delay or disorder)
- Neurodevelopmental disorders – Autism, Intellectual Disability
- Anxiety disorder: Social Phobia, PTSD
- Psychotic disorders – Schizophrenia
- Mood disorders – Depression
- Hearing impairment
- Adjustment Disorder

# Selective Mutism

# Overview

- Case
- Differential Diagnosis
- Diagnosis
- Epidemiology/Genetics
- Co-morbidities
- Assessment
- Treatment
- Etiology
- Clinical Course
- Conclusions

# Selective Mutism

- Inability to speak in certain settings
- Rooted in anxiety
- Usually deemed a very shy child
- Often picked up when starting school, but usually present before age 5
- Can last few months- years

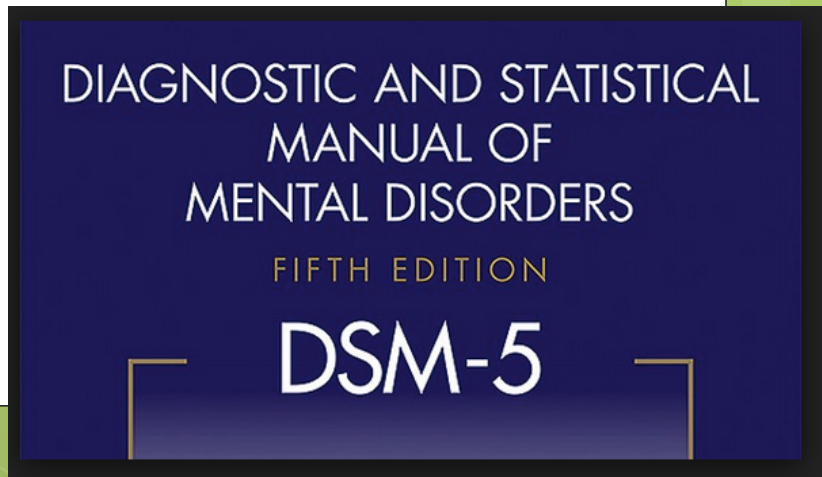
# Definition: DSM V[1]

Diagnostic Criteria:

A. Consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., at school) despite speaking in other situations
B. The disturbance interferes with educational or occupational achievement or with social communication
C. The duration of the disturbance is at least 1 month (not limited to the first month of school)
D. The failure to speak is not attributable to a lack of knowledge or, or comfort with, the spoken language required in the social situation
E. The disturbance is not better explained by a communication disorder (e.g., childhood-onset fluency disorder) and does not occur exclusively during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder

# Changes in new DSM-V

- Previously listed under "Disorders first diagnosed in Infancy, Childhood, and Adolescence"
- Now listed under "Anxiety Disorders"
- In previous DSM version, was labeled "Elective Mutism" – changed to conceptualize the disorder as more biological rather than psychodynamically based



# Background[2,7]

- Selective mutism was first identified in the 19th century when Kussmaul named it *asphasia voluntaria* in 1877 to describe the condition where individuals would voluntarily not speak in certain situations
- 1934 the disorder was renamed *Elective mutism* by psychiatrist Moritz Tramer
- DSM III: Elective Mutism
- DSM IV, 1994: Selective Mutism

# Epidemiology[3]

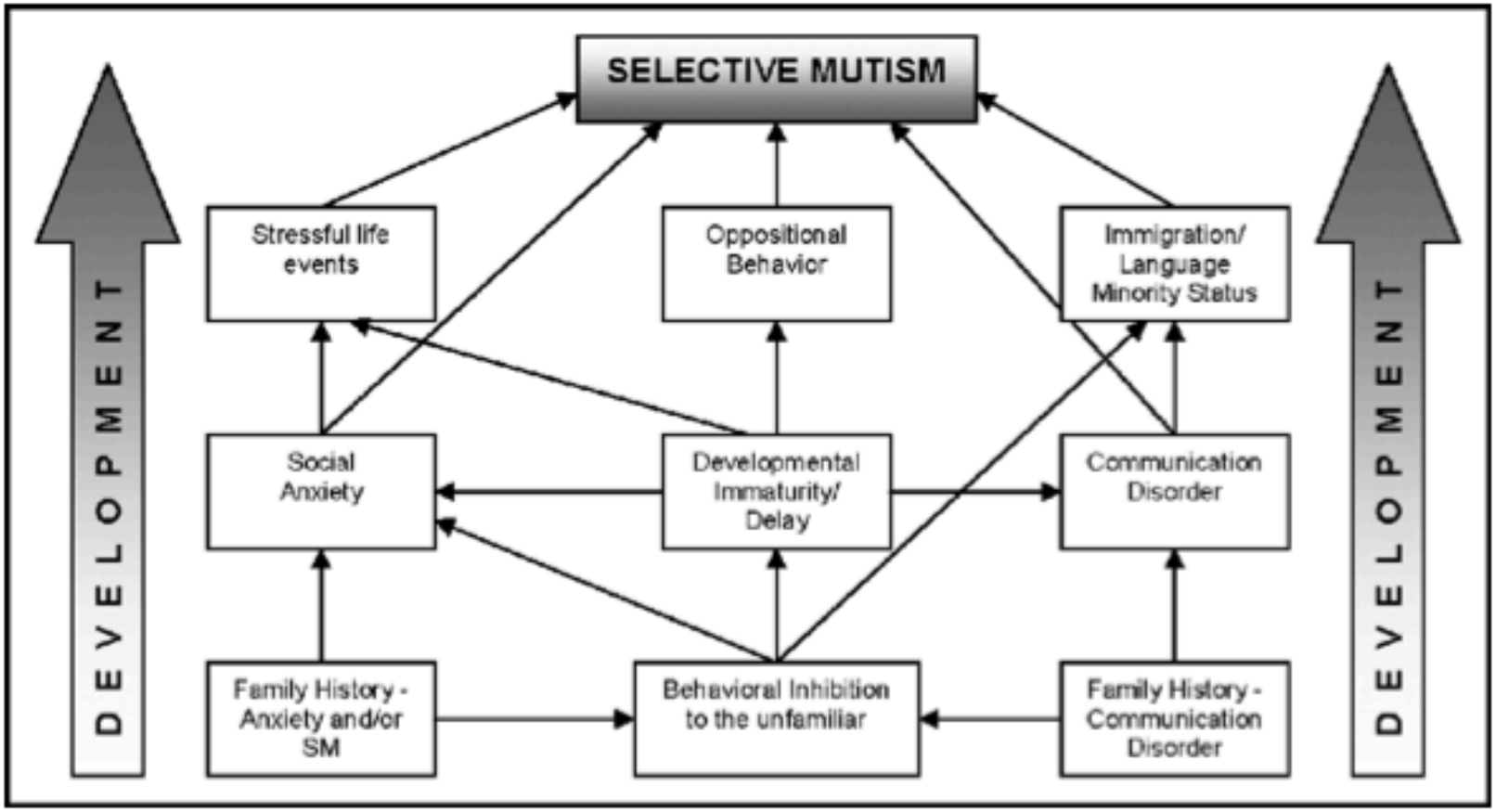
- 0.1-0.7% of children
- Occurs between 3-6 yo
- Diagnosis 5-8 yo
- Higher prevalence in kindergarten and first grade
- Girls: Boys, 2:1
- No causal relationship with neglect, abuse or trauma

# Genetics

- 1st degree relative with social phobia (70%)or selective mutism (20-40%)[3]
- Shyness 35-60% parents[2]
- Depression 20-30%[2]
- No genetic or twin studies done

# Etiology[4,2,7]

- Theories include:
  - Psychodynamic theory: unresolved conflict
  - Behavioral theory: learned behavior in response to triggers
  - Social anxiety and phobia: along the continuum
  - Family systems perspective: intense attachment to parents leads to distrust of outside world
  - Response to Trauma: associated with PTSD
  - Developmental Psychopathology theory: contextual variables interacting with predispositions towards anxiety
- Likely multi-factorial, little empirical data


SELECTIVE MUTISM
DEVELOPMENT
DEVELOPMENT
Stressful life events
Oppositional Behavior
Immigration/ Language Minority Status
Social Anxiety
Developmental Immaturity/ Delay
Communication Disorder
Family History - Anxiety and/or SM
Behavioral Inhibition to the unfamiliar
Family History - Communication Disorder

Ref: 2

# Co-morbidities

- Anxiety disorders, especially social phobia: 75-90%[3 and 4]
- Developmental delay: 65%[4]
  - Speech and language delays present in 20-40%[3]
- Asperger's disorder (now Autism Spectrum Disorder) – 7%[4]
- Other:[3,7]
  - Psychiatric conditions including depression, panic disorders, obsessive compulsive behavior
  - Elimination disorders

# Clinical course

- Remschmidt et al[5]: At 12 yr follow up: 12% still met criteria, 20% mild improvement, 29% partial remission, 39% complete remission. Average duration 9 yrs for remission and 20-30 yrs for no remission at 12 yr f/u. Mostly gradual improvement
- Self perceptions as adults: lower independence, self-esteem, open-mindedness, stress tolerance
- Residual talking behaviors


# Clinical Assessment[4]

- Comprehensive and multimodal approach
  - Parents and teacher surveys
  - Observation of child, ideally both in a clinical and home environment
  - Psychiatric evaluation to rule out other conditions that impede speech, and to evaluate shyness
  - Psychological, psycho-educational, and academic testing
  - Audiology evaluation
  - Speech and language evaluation

# Treatment[3, 4]

- Consists of non-medication and medication based treatments
- Non-medication:
  - Cognitive-Behavioral Therapy
  - Family Therapy
  - School: Team based approach to reduce anxiety and increase self esteem
  - Social skills groups
  - Breathing techniques
- Medication:
  - SSRIs
- Combination of modalities

# Cognitive Behavioral Therapy

- Stimulus fading- requiring less and less prompting to speak
- Positive reinforcement
- Desensitization/gradual exposure
- Extinction- ignoring refusal to speak
- Modeling- videos

# Medications

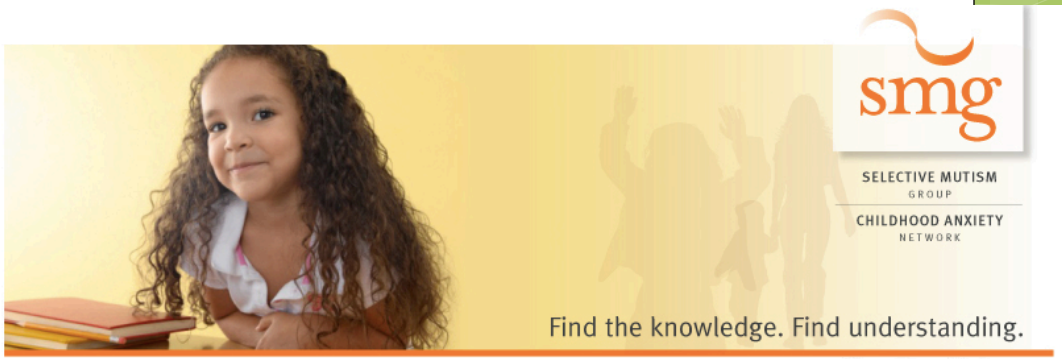

- SSRIs (fluoxetine and fluvaxamine in particular) are the mainstay of pharmacologic treatment
  - Early studies show improvement in 6-8 weeks[4]
- 2nd line may include:
  - Phenelzine (MAOI) – more side effects
  - SNRI[4]
- Studies are lacking, and those that exist have small sample sizes[4]
- Need for more comparative studies to better guide treatment strategies

# CW Case Conclusions

- Assessment: Selective mutism with concern for specific learning disability and/or speech and language impairment with normal cognitive abilities, decreased coping mechanisms, potential social phobia.
  - Recommended for speech and language assessment and IEP evaluation in school
  - Intensive reading and writing instruction
  - CBT at private clinic in San Jose
  - Continue speech therapy at school
  - Endocrinology f/u for decreased growth: constitutional delay and familial short stature. Will get thyroid function tests. Referred to Genetics
  - Defer Neurology consult/EEG for possible absence seizures to PCP

# Talking points

- Did his already delayed speech worsen anxiety leading to selective mutism?
- Would additional speech therapy help him?
- Anxiety disorder vs. speech and language disorder?
- Can refer patients to SMG



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